

RESIGNIFICATION OF DESOMA: PERSONAL EXPERIENCE WITH CARDIAC CHILDREN

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ABSTRACT: This learning report presents the trajectory of a lived experience in the methodological path of qualitative research, of ethnographic nature, based on self-experimentation and self-research in the coexistence with pregnant women and puerperal women - mothers of severe cardiac babies, in a Fetal Cardiology Unit. The interaction with the participants was carried out through interviews, participant observation and active listening, which enabled the construction of narratives, which obeyed the temporal and causal sequence of events. All these events made it possible to re-perspect the evolutionary path, through the understanding of the desoma of cardiac children, replacing a dramatized look in the scenario experienced by new filters, provided by access to the consensual paradigm. The results demonstrated the overcoming of religious postures, the experimentation of parapsychic, interassistential and multi-dimensional skills and through recycling, the resignification of desoma, the understanding of the evolutionary cycle of consciousnesses and groupkarmology.
Keywords: cardiac child; qualitative research; desomatology.

INTRODUCTION

My experience in research with children began in my master's degree in 2005, when I followed 250 mother/baby pairs and their outcomes in the practice of exclusive breastfeeding, in a quantitative observational-based study (Weigert, 2005). During this period, I did not imagine that in my doctorate I would face challenges and difficulties in appropriating the complexity of childhood congenital heart disease. The barriers encountered, such as some attempts at interviews with pregnant women, did not materialize due to the fetal deaths that occurred during pregnancy and to apprehend a new research methodology. While studying the methodology of Qualitative Research, I experienced an approach that allows me to understand, describe and clarify social phenomena according to the experiences, interactions and communications experienced by individuals or groups (Flick, 2009).

In 2014, during the PhD, I experienced the stages of development of qualitative research, which favored my understanding of the importance of theory for the realization of the study. I studied the structuring terms of qualitative research. Minayo (2013) reports that the raw material of qualitative research is composed of

a set of nouns whose meanings complement each other: experience, living, common sense and action. And the movement that informs any approach or analysis is based on three verbs: to understand, to interpret and to dialect. I have studied that qualitative research is not based on a single theoretical-methodological concept, and the various approaches characterize the discussions and direct the practice of the study (Flick, 2009). To do science is to work simultaneously with theory, method and techniques (Minayo, 2013). I understood that the qualitative study can be conducted through different paths according to the chosen theoretical-methodological framework. For Knauth and Leal (2014), the challenge for the deepening of the different phenomena, in the health area, is the alignment of qualitative and quantitative methods, and the need to resume the classic themes of the social sciences and reflect on the sociological and anthropological implications in the studied context. In this sense, when researching the existing aspects of qualitative research, I opted for the ethnographic method, to understand the perception of women, whose severe cardiac babies were born in a hospital service in which I work in the city of São Paulo.

The interviews resulting from this methodological path of qualitative research ended up requiring me to experience energetic interactions with people and environments. I emphasize that through **participant observation** and interviews, I immersed myself in the study scenario, which provided a unique opportunity for learning, self-knowledge, growth and evolutionary level change by understanding new perspectives that, I consider, should be shared with other people. In this direction, I highlight Minayo (2012, p. 623), a renowned Brazilian researcher who said:

Fieldwork is the nurturing mother of all anthropological doubt (...) which consists in knowing that nothing is known, but also in exposing what was thought to be known, to people who [in the field] can contradict [our dearest truths].

Given this scenario, I intend to share through this text, my trajectory of an experience, based on self-experimentation, lived in the methodological path in qualitative research, ethnographic in nature. The term experience historically used by Heidegger (cited by Minayo, 2012) refers to what the human being learns in the place they occupy in the world and in the actions they perform. The meaning of experience is understanding: the human being understands themselves and their meaning in the world of life. This is what happened to me when I lived with pregnant and postpartum women, mothers of severe cardiac babies, in a Fetal Cardiology Unit that allowed access to the Consciential Paradigm. Below I describe the stages of qualitative research and my parallel experience in accessing the Consciential Paradigm.

1. QUALITATIVE RESEARCH

Qualitative research is an interpretive approach to the world, which means that the construction of knowledge and the approximation of the dynamism of life are results of the relationships between individuals present in reality. In this context, the importance of the testimony of the social actors involved, the discourses and the meanings transmitted by them is fundamental, with the researcher being the channel of contact with people and places to observe, record and systematize data from the studied environment (Denzin & Lincoln, 2006; Minayo, 2013).

Qualitative research is a valid and necessary practice in the construction of social life, since researchers who opt for qualitative research, when deciding to discover new investigative paths, do not intend to evade rigor and objectivity, but recognize that human experience cannot be confined to the nomothetic methods of analyzing and describing it (Chizzotti, 2003).

Ethnography, the methodology chosen for this research, is the art and science of describing a human group, its institutions, its interpersonal behaviors, its material productions and its beliefs. The use of ethnography favored my direct contact with the daily lives of mothers of babies with severe heart disease. Thus, I collected data on human experiences lived in order to discern predictable patterns and to describe the various imaginable instances of this experience.

Following the trajectory of these mothers and babies allowed my subjective participation as an observer of those lives. By writing down each speech, feelings and reactions, it was possible to transform and analyze past events, which exist only in their own moment of occurrence, into an account that can be consulted again. In this way, I was able to perceive and understand the experiences and experiences of those mothers, and how in their different cultures they faced reality in the trajectory of the disease of their cardiac children (Geertz, 1999).

The narratives presented by those mothers enabled me, as a researcher, to organize the episodes and facts of daily actions, past time and where they lived. The narrative allowed the inclusion of the participants' reasons for their actions, as well as the causes of the event. I emphasize that language represents reality, so narratives require systematic interpretation; they do not speak for themselves, or provide direct access to time, places or cultures (Sarbin, 1986).

Thus, the study of the narratives presented by the mothers made it possible to understand life in time, to obtain the meaning of events and how much people's actions help in the process of forming their own history, and in whom these mothers are transforming as a result of what they lived (Garro, 1994). From this methodological approach, I developed the doctoral study entitled "Trajectory of

pregnant/postpartum women in a Fetal Cardiology Unit of a Philanthropic Hospital: an ethnographic approach”, which allowed me to resignify the biological death (desoma) of cardiac children by the logic of the evolutionary mechanism of the consciential paradigm. Within the consciential paradigm, according to Carvalho *et al.* (2019), the concept of desoma is the deactivation of soma - replacing the term “death” that refers to “end”, “extinction”. Each person has several bodies, the soma being the most dense and adapted for life in this dimension. I then learned the concept of the holosoma, a set of the four vehicles of manifestation of consciousness: the **soma** or physical body; the **energossoma** or body of energies, also known as the holochakra; the **psychossoma** or body of emotions; and the **mentalsoma**, or body of discernment. Those vehicles or bodies provide consciential manifestation in the various dimensions of existence, from the most subtle to the most dense.

In summary, the choice for qualitative research led me to discover another paradigm, the consciential, reperspecting the central concept of my research: from death to desoma.

2. ABOUT THE THESIS TRAJECTORY OF PREGNANT/POSTPARTUM WOMEN IN A FETAL CARDIOLOGY UNIT OF A PHILANTHROPIC HOSPITAL: AN ETHNOGRAPHIC APPROACH

The thesis was elaborated with the proposal of **understanding**, through listening, participant observation, in a qualitative approach, the perception of pregnant women in the pregnancy and puerperal cycle of babies diagnosed with severe congenital heart disease - **Hypoplasia Syndrome of the Left Heart (SHCE)**, in a philanthropic institution, originated from the action of volunteers from a Syrian Beneficent Association, a pioneer in cardiology, which supports the Ministry of Health through the *Program of Support for Institutional Development of the Unified Health System* - PROADI-SUS (Lara, 2014).

Congenital heart disease (CHD) comprises any change in the anatomy of the heart and its blood vessels. The incidence of congenital heart disease (CHD) is from 8 to 10 per 1,000 live births, that is, 1 case in 100 births. In Brazil, 28,900 children with CHD are born per year (1% of total births), of which about 80% (23,800) require cardiac surgery, and half of them in the first year of life. Congenital malformations represent the second leading cause of mortality in children under one year of age. CHD is the most frequent of them and with the highest mortality in the first year of life in Brazil, being the second cause of death up to 30 days of life. The manifestations of congenital heart disease are very variable and can occur soon after birth, or later in childhood or adolescence (Soares, 2020).

HCS is one of the most severe heart diseases, which corresponds to the fourth most frequent heart disease in neonatal age, with an incidence of 7% to 9% (1:4000 to 6000 live births) and mortality of 25% in the first week of life. SHCE not only represents the most common congenital defect, but also contributes to a higher percentage of infant mortality at birth (Barber-Marcial, Tanamati, 2005; Brenner, Kuehl, 2011; Lara, 2014; Hcor, 2022).

Without treatment, 95% of babies with this syndrome die within the first month of life. To perform the treatment it is necessary to perform three heart surgeries during the first two years of life or a heart transplant. These treatments involve many stressful experiences and risks. Treatments are not a “cure” and children will need specialized care for the rest of their lives (Lara, 2014; Small hearts, 2022).

The theoretical framework adopted for the interpretative analysis of the findings of this investigation was the one referring to the Chronic Disease Trajectory, proposed by Michael Bury (1997), in order to highlight and understand the experience of the participants - mothers of children diagnosed with congenital heart disease. According to this reference, although the disease can happen at any stage of life, society's expectation is for a long and healthy life. Thus, when there is the emergence of the disease, there is also the disruption of the social and cultural structure of the individual, exposing them, consequently, to threats to their identity. In this assumption, three aspects of the response to the experience of chronic disease can be distinguished. The first would be **the biographical rupture**, caused by the disease and the initial attempts to deal with the uncertainty it brings; the second is **the impact** of treatment on daily life and health care; and the third is **the adaptation** and management of the disease, how individuals and family respond to the experience of the disease and try to rebuild their lives. In relation to the rupture of assumptions and behaviors taken for granted, there is a breaking of the boundaries of common sense, which suggests a “disruptive” approach to the disease. This stage, characterized by the question “What’s going on?”, involves attention to bodily states that are not always brought to awareness and decisions about seeking help. Secondly, there are deeper ruptures in the explanatory systems that are normally used by people, such that a fundamental revision of the person's biography and self-concept is involved. Thirdly, there is the reaction to the rupture involving the mobilization of resources, in the face of an altered situation.

Biographical disruption is characterized by the potential loss of identity and loss of control over the body. As a result of bodily changes, the appearance of symptoms and the establishment of the diagnosis, there is a breakdown of ev-

eryday beliefs and behaviors. This stage, translated by the questions: “What is going on? Why me? Why now?” It involves attention to non-conscious aspects and decisions about seeking help. In this study, participants are faced with this stage when discovering pregnancy and, above all, with the diagnosis of congenital heart disease.

In the second phase of the Chronic Disease Trajectory, identified as the **Impact of treatment**, and health care, health services emerge as part of the resources available to face the disturbing effects of the disease, which can provide security to people, but also moments of apprehension and anxiety, since they are arriving at these services with ambivalent feelings. If, on the one hand, they see the possibility of cure or improvement, on the other hand, they become aware of the need to coexist with treatments, interventions and care that are usually mandatory, long-lasting and, in some cases, painful.

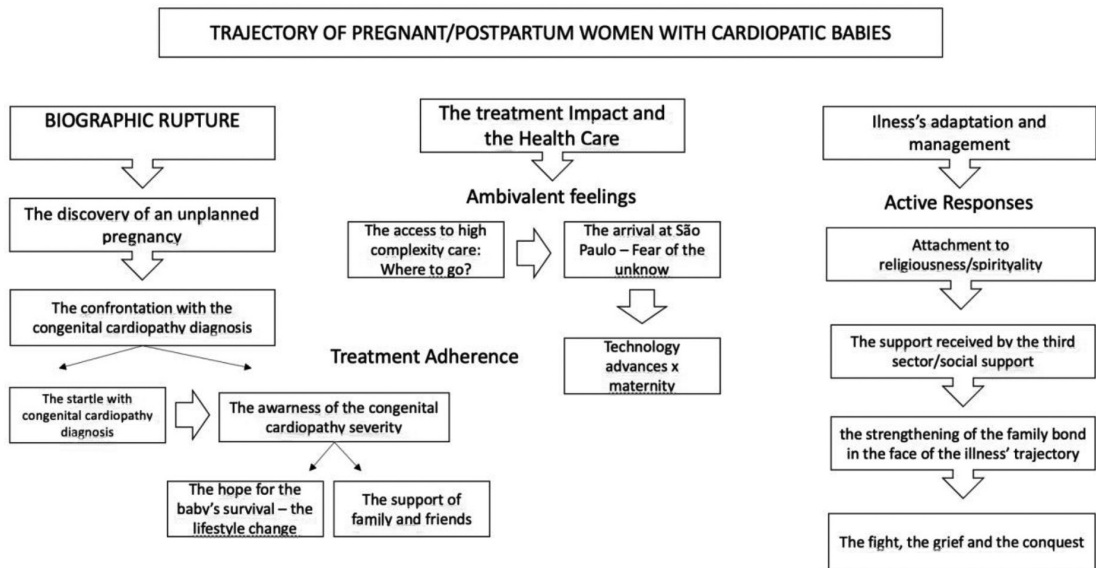
Over time, the person begins to have a greater knowledge about their disease, about the form of treatment and begins a process of understanding the information received from professionals, other patients and the media. Thus, mothers become more confident and establish criteria to evaluate the evolution of the treatment adopted.

The adaptation and management of the disease occurs when there are active responses of individuals to challenges in relation to identity and lifestyle. In this emotional context, family reactions must be taken into account, which are very similar to those of the participants (ambivalence, guilt, anger and mourning). In the family group, the partner plays an important role, due to reactions that can be manifested through support and companionship or feelings of exclusion, resentment, aggression, guilt and others.

The participants in my study were **eight pregnant women**, whose babies have congenital heart disease HCS, from different states of the federation and over 18 years of age. Data were collected in **16 semi-structured interviews**, which occurred at two times: when the participants were still pregnant and after the birth of the babies (puerperal women). **The Theoretical Framework** chosen was **Qualitative Research**, based on **Cultural Anthropology**, with the **Ethnographic Method** and the **Chronic Disease Trajectory Framework** (Lara, 2014).

From the analysis of the narratives, I organized the reports, through careful, reiterative reading, full of questions, impregnated and saturated, which unveiled the meanings and the lived experience, whose main results are contained in the following diagram (Figure 1):

Figure 1. Demonstrative scheme of the trajectory of pregnant/postpartum women of cardiac babies according to the reference of Michael Bury (1997).



Source: Author.

The challenge is to know that many children with heart disease will die from lack of access to high complexity. Although the regulation of access is well established by SUS in theory, in practice what is seen by the specificities of these services is that such alternatives are restricted, generating uncertainties.

As for my experience in this work, dealing with the death of cardiac children inevitably led me to reflect on my role and whether this work was part of my learning. In this perspective, I sought knowledge to strengthen myself with lucidity and discernment in the face of the difficulties that presented themselves: understanding biological death, as well as the interface of the study with Conscientiology.

This study allowed me to experience the meaning of the phrase I heard from Professor Maria Cecilia Minayo: “What good is science if it is not to reduce the suffering of humanity?”. Therefore, knowing how pregnant/postpartum women perceived and evaluated the care provided was of paramount relevance for: 1) rethinking the way the service is organized, highlighting the role of the user as a protagonist of the Unified Health System (SUS), whose contributions can have a direct impact on the improvement of sus; and 2) consequently, inserting a lens that allowed me to observe and understand the phenomenon in its depth (Lara, 2014).

3. SELF-PARADIGMATIC REFLECTIONS ON THIS METHODOLOGICAL PATH

It was necessary to confront and understand the logic of these women and, according to qualitative research, understand what it meant at that moment to have the ability to put myself in the place of the other, respecting their beliefs, their values and understanding that for the operationalization of this study needed to be next to the pregnant women and the team that assisted them. Then, I remembered three non-negotiable principles that I learned from Professor Maria Cecilia Minayo (2013), during the trajectory of the research and that would be fundamental to achieve this purpose, such as:

a) The principle of intersubjectivity: we are made of the same matter and spirit as the people we serve; listening to the pains of the study participants brings an interaction of empathy, reflection, values, that we are vulnerable.

b) The principle of understanding: we have the ability to put ourselves in the other's shoes and understand that each person's experiences and experiences are unique; and that at this moment my role was one of assistance, listening, sharing.

c) The principle of respect for the rationality of any human being: we are able to produce truths about ourselves and about the world.

However, when experiencing the interaction with the study participants, I came across some barriers that needed to be overcome, which led me to reflect on the paradigmatic limits regarding death and how to assist bereaved mothers.

1. My lack of knowledge about the procedure for the correction of congenital heart diseases: when I arrived at HCor I always heard about the icon of Congenital Heart Disease Care, Professor Dr. Adib Jatene (1929-2014), responsible for the development of the "Jatene Surgery" technique to correct the transposition of the great arteries. I heard many stories in the interviews, the accounts of the testimonies, for example: "the doctors were going to put a valve that needed to pass through the belly hole. This valve was going to pass through the umbilical cord and go to the baby's vein, which was clogged and was going to fill a little balloon. When the little balloon filled, the vein would unclog and they would take the little balloon out so that the heart would beat again." This procedure was done intrauterine and, as soon as the baby was born, would already have surgery. I got to know through the narratives and then talked to the team that explained the procedures to me. Many babies went through the hybrid procedure, which is a treatment that involves an interventional surgical and hemodynamic procedure. The procedure consists of bandaging the pulmonary arteries and implanting a *stent* in the arterial duct. For me it was difficult to think about *stenting* and

performing heart surgery on adults, let alone newborns. Several situations of this type have strengthened me to address the disease.

2. How to approach the disease: when pregnant women arrived at the Fetal Cardiology service of HCor, they had already gone through the recognition of the disease at the prenatal moment, families arrived with hope for the cure of their babies. Families obtained information from emotional preparation to acceptance of the disease. The earlier the diagnosis of SHCE, the longer the multidisciplinary team can work in a timely and rational manner with the family, for the counseling and guidance of the prognosis in the short and long term, as well as what will be the treatment options and the expected results (Abrahão, 2019, p.179). My behavior was listening, learning, interacting with a lot of rationality and welcoming.

3. How to help pregnant women and mothers of desomated cardiac babies to face grief: she talked to psychologists, as the pregnant women had psychological follow-up from entry into the Fetal Unit care program to follow-up in the delivery room. The announcement of the anomaly, lived as a wound and a humiliation, is at first an emotional cataclysm from which it is difficult to escape. The baby's dream is broken. Death and illness are very close" (Abrahão, 2019, p 67). Faced with the death of the baby, a post-obitus outpatient clinic or referral of the mother to an external psychotherapy service was offered. My interviews, in the case of babies who died, were after this stage. I noticed that qualified listening and interactions were of great help, because in our interviews they showed a feeling of gratitude, despite the outcome.

That is, the initial impact of dealing with delicate and complex surgical procedures and with bereaved mothers led me to seek new consciencial resources to assist these mothers and also with my self-paradigmatic conflicts regarding death, as I describe in the next topic.

4. ACCESSING THE IDEAS OF CONSCIENIOLOGY

In the current intraphysical life, between late adolescence and early adulthood, I suspected that I had some work to do with children. I sought training in the field of health. I started my activities in hospitals, working in the pediatric maternity and pediatric intensive care unit (UTIPED). I lived with mothers of babies in serious condition and sometimes divine evocation was a comforting resource in the assistance interaction. I would deal with tranquility, always positive and communicative, and sometimes religion was consolation and hope: "*everything will be alright*".

When one thinks of the possible emotional repercussions of the parents of a cardiac child, one must first consider the symbolism that the heart carries

with it: meanings are attributed relative to the mainly affective characteristics of a person, such as kindness, generosity and character. Such meanings provide the emergence of a series of fantasies related to the personality of the child to come (Abrahão, 2019, p. 67).

In this research, self-confrontation was inevitable. Religious postures alone could no longer attend to these women, whose babies had one of the most serious heart diseases, the SHCE. At this moment, I realized I had dogmatic beliefs, such as: chastising, guilt, punishment, sin, fear of physical death, aversion to some process related to the biological death of the human body, especially of children, Thanatophobia - “father and mother of all human fears and phobias” (Strachicini, 2019, p. 43) - and of experiencing the mourning of mothers and families.

Another way of thinking is that of the conscientiological view¹, in which death is known as desoma, that is: “The desoma (des + soma) is the deactivation of the soma, the human body, in the short or long term, an exclusive, close and inevitable condition for all conscins (Vieira, 2003, p. 942). According to Strachicini (2019), the ignorance of the multiexistential and multidimensional essence is what explains the fear of death. The certainty that we are a consciousness (or soul) that has a body and not a body that has a soul, can help and extinguish this fear. Consciousnesses are not lost, but are found again to make adjustments called groupkarmic, evaluate errors and successes and make corrections of evolutionary course, which occur both in intraphysicality and extraphysicality.

I realized that it was essential to demystify several religious beliefs and mainly find clarifications about taboos, fears and de-dramatize the desoma through the search for emotional stability and rational positioning in the face of biological death (Carvalho, 2019), such as, for example, the belief that we were born to have a long and happy life, which leads to the non-acceptance of death in children.

Living in a crisis of paradigm conflict: how to de-dramatize the desoma of cardiac children?

I ask this question because, previously, the process of dramatization was evident in this context, because at each desoma the religious bias was always present. An example of this was given to each death of these children, where the feeling of guilt, loss and punishment were always present. However, I managed to overcome these situations. These concerns and reflections led me to study Conscientiology

1. “Conscientiology is the Science applied to the study of consciousness in a comprehensive, integral, multidisciplinary, multicultural, multidimensional, multitemporal, multiexistential, holothosenic, holosomatic, holomnemonic, holobiographical, holokarmic way and, above all, according to the reactions to immanent energies and consciential energies, as well as the multiple states, levels of acuity and conditions of manifestation, through the self- and heteroresearch of mentalsomatic, paracerebral attributes and consciential phenomena in general” (Vieira, 2003, p. 82 and 83).

and I began to de-dramatize the events due to the process of transition from the religious paradigm, previously experienced, to the **Consciential Paradigm, with its new learning**. The ideas involved in this transition are described in Table 1.

Table 1. Comparison religious paradigm - consciential paradigm

RELIGIOUS PARADIGM	CONSCIENTIAL PARADIGM
Unquestionable Truths	Cutting-edge relative truths: refutable, questionable and verifiable
“Believe now, live with an unproven hypothesis until the day of your death.”	Principle of disbelief, don't believe anything, have your own experiences
Guilt, chastising, punishment	Recycling, evolution, groupkarmality
Outsourcing	Autonomy
Setting	Growth crisis
Passivity	Self-effort.
Fear of death	Understanding the Multiexistential Cycle and Continuity of Consciousness

With the paradigm transition it became evident that this author carried the thosenity in the sen (feelings-emotions). In fact, I was unaware that auric couplings between two consciousnesses could intervene in my emotions. When I gained an understanding of the holosomatic balance, I was able to improve the lucidity and assistance to the study participants.

Through the neoscience, I had the opportunity to access new filters, because consciousness is, at the same time, subject, object and instrument of consci-entiological research. Thus, self-research led this author to identify the traits that can be self-recycled – intimate change, without which evolution does not occur.

In short, the important fact in this trajectory was the intraconsciential recycling experienced, providing changes for the better, through a new understanding of human existence, overcoming dogmatic beliefs, such as “delivering events to the divine”.

5. GATHERING FROM EVOLUTIONARY LEARNINGS ABOUT DESOMA

I began to acquire new synapses and with the movement of energies the interaction with the study participants happened with more discernment, feeling the need to detach from the outdated personal paradigm. I would observe patterns of victimization, by the interference of suffering consciexes, seeking to assist and realizing that the facts experienced are an opportunity for groupkarmic recompositions.

Thus, based on the principle of groupkarmic inseparability, *that no one loses anyone*, mourning for the desoma of children ceased to be a burden, becoming

this author more rational, being able to focus on qualifying interassistance with the mothers of these children.

Another point to highlight was the possibility of interacting energetically with the companions of the research participants, as they accompanied them to the place where the interviews took place.

Between comings and goings to visit the babies, in the ICU, I met with these parents and talked about the evolution of the babies. On one of these occasions, I went to visit one of the participants in the Inpatient Unit, and the father, who had accompanied the birth, reported the happiness of seeing his son, and the love he had felt. I felt privileged to share these special moments of their lives and observed how much these lines strengthened the bond between the couple. Also in these moments I felt the presence of function helpers and the energetic baths were noticeable.

In possession of conscientiological neologisms, I had the opportunity to talk to couples about babies who did not survive and, when we entered the field of spirituality, some spoke in other lives, that “it was written that it would be so”. My impressions were that they already had parapsychic information and I, then, already had a little more lucidity on the subject. Obviously, I did not openly address the new studies on the Consciential Paradigm. I respected parents’ beliefs and cultures, but experienced parapsychic phenomena.

In all this research work, I was able to experience some retrocognitions that brought a better understanding of working with children in this intraphysical life. In one of these experiments I obtained information about having been, in a previous life, negligent with a certain group of children in a certain location in Europe.

I experienced projections with a baby who warned me of desoma (biological death), called in Antefinal **Projection** conscientiology (Vieira, 2019, p.146) – Experience of consciousness outside the human body, involuntary or forced, common to terminally ill people in which consciousness says goodbye to family and friends. I hypothesize that the baby consciousness accompanied all my care interventions to their treatment of the soma.

I noticed that babies who spent little time in this dimension united the couples; my reflections were many; a lot of recycling opportunities. One of the most important questions I learned was about listening, I had a prescriptive way of being, always pointing out ways, but I learned through the methodology of the interview and the experience of parapsychism, welcoming, listening to mothers and their narratives and perceiving a great opportunity to experience interassistance.

From my lessons learned lies the understanding of the immortality of consciousness. I had the opportunity to take many courses and to have my own ex-

periences; I accessed numerous verbets that were very enlightening to me, among them some that helped me to reflect on the desoma. For example, I highlight the verbet Culture of Desomatology² (Lopes, 2012).

I also discovered the Penta Technique³. When I attended the International Institute of Projectiology and Conscientiology, at the Center for Advanced Studies in São Paulo - IIPCqCEA/SP, a place where the writing of my thesis flowed, I made a request for Penta for cardiac children.

I discovered that I was a pentable conscin, which has as its definition “the person interested in acquiring understanding about the evolutionary task of penta, aiming to prioritize consciential evolution in assistantial work, and who is not yet a penta practitioner” (Thomaz, 2015, p. 71). However, I assessed that when I made numerous requests for PENTA for children with heart disease, I had not yet reached the condition of an Antidogmatic Consciousness⁴.

It was becoming clear to me that “the consciousness is more than the conscious state, reason or ethics, being defined as the subject itself, the person researched and understood under the approach of a consciential principle, ego, personality, self, spirit, soul, essence, in a continuous evolutionary process, with possibilities of manifestations in different bodies, dimensions, lives - multimillennial experiences and in many dimensions, places and planets” (Cerato, 2005, p.17).

Based on these new studies, from Conscientiology, I identified and sought to overcome my own inconsistencies in the process of self-paradigmatic transition, through some self-prescriptions:

1. Not just being a consumer of Conscientiology, trying to evolve with effort, self-effort and self-research (Remédios, 2012).

2. Do not assume conscientiology as absolute truth – use the principle of disbelief – consider experiencing and admitting anything without questioning and reflecting. Prove everything by self-experience (Vernet, 2020, p. 35).

2 “The Culture of Desomatology is the material of theoretical knowledge, the pattern of behaviors, the set of customs and the body of evolutionary values that form the neomundividence related to the deactivation of the physical body, understood as a natural passage to another paravivencial condition alternating to human existence, gradually implemented by the conscin, man or woman, researcher of conscientiological verpons” (Lopes, 2012).

3 “Penta is the transmission of consciential, assistance, individual energy; performed every day, 7 days a week, 365 days a year, with a fixed schedule; Technique applied with total intraphysical isolation of consciousness, work assisted by a helper or extraphysical helpers, practiced in ordinary physical wakefulness, that is, by intraphysical consciousness. It has an assistantial focus: the needy or sick consciences, intra or extraphysical” (Vieira, 2011, p.11).

4 “Antidogmatic Consciousness: it is the condition of autonomy assumed by women or men, acting lucidly in the full exercise of free will, in the act of making lucid choices for their own lives, acting by their own will, rejecting others’ coercive opinions, unverifiable absolute truths, doctrines and dogmas of all natures and, from that, dynamizing personal and group existence” (Strachicini, 2019, p.21).

3. Conquer bioenergetic autonomy through the Vibrational State Technique (Bolfe, 2020, p. 15).
4. Qualify the thosenes (Kunz, 2016, p.28).
5. Qualify parapsychism through discernment (Weigert, 2021, p.41).
6. Identify priority recycling.

In this direction I understood another pillar of conscientiology, **cosmoethics**. The evolution of consciousness necessarily takes place in a group, along with other evolutionary companions. I recognize that coexistence with the study participants is part of my trajectory in this intraphysical life. Nobody evolves alone. “Cosmoethics is the *Cosmic Ethics*, multidimensional, broader than intraphysical ethics, governing consensual interactions in multiple dimensions” (Vernet, 2021, p. 26).

I experienced the welcoming of the numerous conscientiocentric institutions by the various courses I took and the numerous tertulias I attended, leading me to concerns mainly in applying the scientific method in the studies of my self-research. I accessed an orthopensata from Professor Waldo Vieira that says:

Scientific self-research is the main solid support that the Human Being has against irrationality, obscurantism, mega-immaturities and subcerebral washes of all nature that camp and subvert Socin, when still pathological (Vieira, 2019a, p.223).

I really like the notion of self-research, which involves the search for self-knowledge in a technical way and, therefore, leads to the acceleration of intraconsensual recycling, which can generate an evolutionary level change.

FINAL CONSIDERATIONS

From articles and verbets in Conscientiology, I came across the infinite possibilities of addressing the topic and the need to advance in the construction of interassistential scientific knowledge. This meant thinking about how to write a research project based on the conscientiological methodology to organize the interassistential, self and maxiproexological fronts, identifying and describing my target audience and building personal multidimensional meanings (Kauati, 2014; Zaslavsky, 2021; Weigert, 2021). Thus, I consider this stage of self-paradigmatic transition to be an evolutionary opportunity.

I realized throughout the trajectory the qualification of the assistance provided, moving from a limited condition of religious beliefs, to a more advanced condition of consensual autonomy. I knew tools that allowed me to expand the assistance provided to conscins and concixes assisted in this context, in partner-

ship with technical function helpers. For example: clarification tasks, basic mobilization of energies, penta, projection and conscientiological teaching.

All these events made it possible to re-perspect the evolutionary path, through the understanding of the desoma of cardiac children, replacing a dramatized look in the scenario experienced by new filters, provided by access to the consciential paradigm. As a consciousness that feels tireless in the assistential condition, I hope to have clarified about how my process of resignifying the desoma was.

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